MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04468 04465

1. PLACE OF DEATH
a. COUNTY: CHARLES
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LA PLATA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle MARCELLUS Last BIVINS

4. DATE OF DEATH: Month APRIL Day 4 Year 1962

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 16, 1888

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JAIL KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: COUNTY JAIL

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RICHARD BIVINS

14. MOTHER'S MAIDEN NAME: MARTHA HEMSLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-16-3088

17. INFORMANT: AGNES F. BIVINS, Address: LA PLATA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-4 19 62 to 4-4 19 62 that (I) (we) last saw the deceased alive on 4-4 19 62 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-4-62

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-7-62

23c. NAME OF CEMETERY OR CREMATORY: SACRED HEART

23d. LOCATION (City, town, or county) (State): LA PLATA, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The Hunt Funeral Home, ADDRESS: WALDORF, Md.

25a. REC'D BY REGISTRAR DATE APR 10 '62

25b. REGISTRAR'S SIGNATURE: Clarence S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the funeral or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04469 04466

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La Plata
d. STREET ADDRESS: Prospect Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MITCHELL — Middle CLARK — Last COCHRANE

4. DATE OF DEATH: Month April — Day 1 — Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 5, 1900
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Howard Drug, Co.
11. BIRTHPLACE (State or foreign country): La Plata, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Mitchell Cochrane
14. MOTHER'S MAIDEN NAME: Rebecca Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-09-7978
17. INFORMANT — Address: Mrs. Loretta Cochrane - (Wife) - La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — 12 HRS
527.1
DUE TO (b): SECONDARY POLYCYTHEMIA, SEVERE — > 1 YR.
DUE TO (c): EMPHYSEMA — > 1 YR.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ACUTE CARDIO PULMONARY FAILURE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JAN 1962 to APR. 1 19 62 that (I) (~~not~~) last saw the deceased alive on APR 1 19 62 and that death occurred at 24 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Merkle M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: APR 1, 62
22c. PHYSICIAN'S NAME (Type): Robert W. Merkle, M.D.
22d. ADDRESS: La Plata, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/3/1962
23c. NAME OF CEMETERY OR CREMATORY: Mt. Rest Cemetery
23d. LOCATION (City, town, or county) (State): La Plata, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Arehart Funeral Home, Inc. * La Plata, Md.
25a. REC'D BY REGISTRAR DATE: APR 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the funeral or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04470

CERTIFICATE OF DEATH

04467

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWPORT-RURAL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWPORT- RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First RACHAEL Middle ANN Last DORSEY

4. DATE OF DEATH: Month Apr Day 7 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ? 1874

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY DORSEY

14. MOTHER'S MAIDEN NAME: MARGARET MIDDLETON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: JOSEPH DORSEY, Hughesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 to Apr 7 1962, that (I) (we) last saw the deceased alive on Feb 19 62 and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: F. M. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-7-62

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON

22d. ADDRESS: La Plata, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-9-62

23c. NAME OF CEMETERY OR CREMATORY: ST MARYS

23d. LOCATION (City, town, or county) (State): NEWPORT, MD.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hunter Funeral Home, WALDORF, MD.

25a. REC'D BY REGISTRAR DATE APR 10 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the medical or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

M

99

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04471

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04469

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please notify the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Virginia — b. COUNTY: Henrico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Richmond — 83 x 3
   d. STREET ADDRESS: 2306 Brockway Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Lafey Alma — Last: Greene

4. DATE OF DEATH: Month: April — Day: 3 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-26-1916

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clifford La Fey

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Frank Greene (Husband) — Address: 2306 Brockway Lane Richmond, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Depressed Skull Fracture Left Temporal Area — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Crushed Chest — 20 min.

DUE TO

(c) Auto Accident — 20 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Driver of auto which pulled into path of a truck

20c. TIME OF INJURY — Hour: 8:30 a.m. p.m. — Month, Day, Year: 4-3 19 62

20d. INJURY OCCURRED — While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Newburg — (County): Charles — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Merkle M.D.

EXAMINER'S NAME (Type): Robert W. Merkle, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): La Plata, Md.

DATE SIGNED: 4-4-1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 4/4/1962

22c. NAME OF CEMETERY OR CREMATORY: Wooddy Funeral Home

22d. LOCATION (City, town, or country) (State): Richmond, Virginia

23. FUNERAL DIRECTOR: Arehart Funeral Home, Inc. — ADDRESS: La Plata, Md.

24a. REC'D BY REGISTRAR — DATE: APR 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Rivers

VS. A15ME
5M 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is nec... please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be ret... for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04472

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04470

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dist. No. 1
c. LENGTH OF STAY IN 1b: 12 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mrs. Mary Hospital
d. STREET ADDRESS: US Edmonston St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MASS
b. COUNTY: Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Braintree — 58 x 3

3. NAME OF DECEASED (Type or print): First CHARLES Middle ARTHUR Last HALES
4. DATE OF DEATH: Month 4 Day 7 Year 196 2

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-28-97
9. AGE (If years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: Deck Steel
11. BIRTHPLACE (State or foreign country): Henderson Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Hales
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: 024038086
17. INFORMANT: Oliver Hales. Address: Braintree Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4-7-62
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. J. Dolen M.D.
EXAMINER'S NAME (Type): E. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 4-7-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/11/1962
22c. NAME OF CEMETERY OR CREMATORY: Blue Hill Cemetery
22d. LOCATION (City, town, or country) (State): Braintree, Massachusetts

23. FUNERAL DIRECTOR: Arehart Funeral Home, Inc.
ADDRESS: Arehart Funeral Home, Inc. La Plata, Md.
24a. REC'D BY REGISTRAR DATE: APR 18 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

Items 18-21 Film 313 [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04471

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: MARYLAND | D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Phys. Memorial Hospital D.O.A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marshall Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DORIS Middle Loraine Last HALEY

4. DATE OF DEATH: Month April Day 29, Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1921

9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Indian Head, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Judson Pullian

14. MOTHER'S MAIDEN NAME: May Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 573-18-4536

17. INFORMANT: Mr. Edward L/. Haley -Husband- Address: Maryland Marshall Hall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Barbiturate intoxication — INTERVAL BETWEEN ONSET AND DEATH

871.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): acute alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Ingestion of overdose of barbiturates

20c. TIME OF INJURY Hour XXXX p.m. Month 4/ Day 8 Year 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): House- home

20f. (City or town): Marshall Hall (County): (State): Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Peter W Rieckert M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Peter W. Rieckert, M.D.

Medical Investigator x

Address (Street, city, town, or county):

DATE SIGNED: 4/30/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burail

22b. DATE THEREOF: 5/2/1962

22c. NAME OF CEMETERY OR CREMATORY: Bumpy Oak Cemetery

22d. LOCATION (City, town, or country): Pomonkey, Maryland (State):

23. FUNERAL DIRECTOR: Arehart Funeral Home, Inc.

ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.

24a. REC'D BY REGISTRAR DATE: MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04474

04472

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible] PHYSICIANS MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE [illegible] MARYLAND
b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X [illegible] JANTION
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: F. Middle: DESALES Last: HARPER

4. DATE OF DEATH: Month APRIL Day 13 Year 1962

5. SEX: [illegible]
6. COLOR OR RACE: [illegible]
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 17, 1[illegible]
9. AGE (In years last birthday): 1[illegible] yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]ING
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Harper
14. MOTHER'S MAIDEN NAME: Rebecca Makle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Posterior Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b) Arteriosclerosis — 10 yrs

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12, 1962 to 4-13, 1962 that (I) (we) last saw the deceased alive on 4-13 1962 and that death occurred at 9:[illegible] AM, from the causes and on the date stated above

22a. SIGNATURE [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 4-13-62
22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.
22d. ADDRESS LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) [illegible]
23b. DATE THEREOF [illegible]
23c. NAME OF CEMETERY OR CREMATORY [illegible]
23d. LOCATION (City, town, or county) (State) [illegible]

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [illegible]
25a. REC'D BY REGISTRAR DATE APR 17 '62
25b. REGISTRAR'S SIGNATURE Arthur E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the funeral director, if necessary, and page 3 by the medical or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04475 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04473

Items 18 & 21, File 6-312 5/7/62 cac

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patuxent City
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patuxent City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BESSIE Middle Last LOCKS
4. DATE OF DEATH: Month April Day 15, Year 19 62
5. SEX: Fmeale
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baschill N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert Ennis
14. MOTHER'S MAIDEN NAME: Catherine Jane
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) If yes give war or dates of service:
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Malmen Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute alcoholism
322.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Russell Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county):
DATE SIGNED: 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-26-62
22c. NAME OF CEMETERY OR CREMATORY: Baschill Cem
22d. LOCATION (City, town, or country): Baschill C. (State): N.C.

23. FUNERAL DIRECTOR: Chas C. Wilson
ADDRESS: Ivanhoe
24a. REC'D BY REGISTRAR DATE:
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9;6D

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04476 — 04474

1. **PLACE OF DEATH**
a. COUNTY: CHARLES COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARBURY
c. LENGTH OF STAY IN 1b: 4 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD 1 MARBURY

2. **USUAL RESIDENCE** (Where deceased lived, if institution) Residence before admission)
a. STATE: MD.
b. COUNTY: CHAS. CO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARBURY
d. STREET ADDRESS: RFD 1 MARBURY
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARTHA — Middle BIRD — Last MILLS

4. **DATE OF DEATH**: Month 4 — Day 25 — Year 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 2, 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State or foreign country): KING GEORGE, VA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT GARNER

14. MOTHER'S MAIDEN NAME: JANE SCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO.

16. SOCIAL SECURITY NO.: NONE.

17. INFORMANT: MARY MAGDALENE SOUTHERLAND — Address: MARBURY, MD

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b) and (c)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): 331 X — VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 1 MINUTE

DUE TO (b): HYPERTENSIVE DISEASE — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying last. DUE TO (c): OLD AGE, ARTERIOSCLERSIS — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FLU WITH PNEUMONIA FEB 1962

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from FEB, 1962 to 4/25/, 1962 that (I) (saw) last saw the deceased alive on Mar 10, 1962 and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Merkle M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/25/62

22c. PHYSICIAN'S NAME (Type): ROBT. W MERKLE

22d. ADDRESS: LA PLATA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/27/1962 — 23c. NAME OF CEMETERY OR CREMATORY: Chicamuxen Methodist — 23d. LOCATION (City, town or county): Chicamuxen, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc. — ADDRESS: La Plata, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Truma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04477

CERTIFICATE OF DEATH

Reg. Dist. No. 04175

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
c. LENGTH OF STAY IN 1b: 2-Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 211 Holden Road

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md
d. STREET ADDRESS: 211 Holden Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Francis Last Murphy

4. DATE OF DEATH: Month 4-4-62 Day Year 19

5. SEX: Male

6. COLOR OR RACE: W-US

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-1-23

9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.

11. BIRTHPLACE (State or foreign country): Norfolk,Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Francis Murphy

14. MOTHER'S MAIDEN NAME: Marion Veronica Titmuss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO: 229-14-9918

17. INFORMANT: Wife-Mrs J.F.Murphy Address: 211-Holden Road, Indian Head Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-29-62, 19____, to 4-4-62, 19____, that I last saw the deceased alive on 4-4-62, 19____, and that death occurred at 10-30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: James E. Andrews M.D. 17-Potomac Ave.Indian Head Md. 4-4-62

PHYSICIAN'S NAME (Type): James E.Andrews MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/7/1962
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Norfolk , Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Arehart Funeral Home, Inc. Arehart Funeral Home , Inc. - La Plata , Md.

24a. REC'D BY REGISTRAR DATE: APR 9 '62

24b. REGISTRAR'S SIGNATURE: Clifton L. Yeatman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
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(M) (C) 66

TO HOSPITAL OR ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after dea age 4 may be ned by the at or attending phys'cian. After this certificate has been signed by the attending physician and completely filled by the funeral director, TO FUNE DIRECTOR page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04478

CERTIFICATE OF DEATH

04476

1. PLACE OF DEATH a. COUNTY: CHARLES MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIANS MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BRYANTOWN
d. STREET ADDRESS: |
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: RONALD Middle: LEE Last: PICKERAL

4. DATE OF DEATH Month: APRIL Day: 3 Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 31, 1962

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months: Days: 3 — IF UNDER 24 HRS Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CURTIS PICKERAL

14. MOTHER'S MAIDEN NAME: NANCY ANN McKINSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: CURTIS PICKERAL, BRYANTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): incomplete alveolar expansion — INTERVAL BETWEEN ONSET AND DEATH: 3 days
7 7 + 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): prematurity — 3 days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congenital malformation of the mandible & pharynx

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-31 1962 to 4-3 1962 that (I) (we) last saw the deceased alive on 4-2-1962 and that death occurred at 4 AM, from the causes and on the date stated above

22a. SIGNATURE: F. M. Johnson M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-3-62

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-5-62

23c. NAME OF CEMETERY OR CREMATORY: St MARYS

23d. LOCATION (City, town, or county) (State): BRYANTOWN, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Huntt Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 15M 9/59

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04479

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04477

1 PLACE OF DEATH
a. COUNTY: CHARLES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HUGHESVILLE-RURAL
c. LENGTH OF STAY IN 1b: MARYLAND LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HUGHESVILLE-RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: BENJAMIN Middle: Last: THOMAS

4 DATE OF DEATH: Month: APRIL Day: 9 Year: 1962

5. SEX: MALE

6 COLOR OR RACE: NEGRO

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: SEPT. 5, 1880

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: BENJAMIN THOMAS SR.

14. MOTHER'S MAIDEN NAME: UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Address: ESTELLE THOMAS, HUGHESVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL - VASCULAR ACCD. — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO (b): ARTERIOSCLEROSIS OF — UNK.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): OLD AGE — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 a.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [✓], Inquiry [✓], and in my opinion death resulted from: Natural causes [✓] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: R. W. Mehle M.D

EXAMINER'S NAME (Type):

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [✓]

Address (Street, city, town, or county):

DATE SIGNED: 4/10/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-12-62

22c. NAME OF CEMETERY OR CREMATORY: ST MARYS

22d. LOCATION (City, town, or country) (State): BRYANTOWN, MARYLAND

23. FUNERAL DIRECTOR ADDRESS: The HUNTT FUNERAL HOME, WALDORF, MD.

24a. REC'D BY REGISTRAR DATE: APR 13 '62

24b. REGISTRAR'S SIGNATURE: Clifton S. Hance

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

[illegible]

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04480

04478

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HUGHESVILLE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X HUGHESVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REBECCA Middle Last WILLIAMS

4. DATE OF DEATH: Month APRIL Day 19 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 19, 1961

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months 4 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES LEE TAFT

14. MOTHER'S MAIDEN NAME: MARY K. SEWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Address: MARY K. WILLIAMS, HUGHESVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured Bronchitis (acute) — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): acute Chest cold — 4 day

DUE TO (c): acute upper Respiratory Cold — X day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 500X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar, 1962, to April 19, 1962, that (I) (we) last saw the deceased alive on April 18, 1962, and that death occurred at 4A.M, from the causes and on the date stated above.

22a. SIGNATURE: Vaheh M. Seron M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/19/62

22c. PHYSICIAN'S NAME (Type): VAHEH M. SERON MD

22d. ADDRESS: AQUASCO, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-19-62

23c. NAME OF CEMETERY OR CREMATORY: ST MARYS

23d. LOCATION (City, town, or county) (State): BRYANTOWN, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Hathaway Funeral Home, Waldorf, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE APR 23 '62

25b. REGISTRAR'S SIGNATURE

1-020518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the funeral director or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04491

CERTIFICATE OF DEATH

Reg. Dist. No. 04179

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Aquasco
c. LENGTH OF STAY IN 1b 40 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Aquasco
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last YOUNG
4. DATE OF DEATH Month April Day 17 Year 1962
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 14, 1881
9. AGE (If years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John W. Young
14. MOTHER'S MAIDEN NAME Mary Ann Trueman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-36-1846
17. INFORMANT Mrs Wm Henry Young Address RR Brandywine

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 1 week
DUE TO (b) Cerebro Vascular Renal Failure — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Valvular Disease — Years
421.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 11, 1960 to April 17, 1962 that I last saw the deceased alive on April 17, 1962, and that death occurred at 5:__ P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Walter M. Seron M.D. ADDRESS (Street, city or town, state) Aquasco Md DATE SIGNED 4/19/62

PHYSICIAN'S NAME (Type) WALTER M. SERON M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 4-20-62
22c. NAME OF CEMETERY OR CREMATORY ST MARYS
22d. LOCATION (City, town, or county) (State) AQUASCO, MD.

23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home ADDRESS Waldorf, Md.
24a. REC'D BY REGISTRAR DATE APR 23 '62
24b. REGISTRAR'S SIGNATURE Caroline S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55